ICD-9-CM
Basic Coding Steps and Guidelines

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Code Assignment

- **Determine principle diagnoses**
  - Reason for encountering health care system
- **Locate the main term in the Alphabetic Index**
- **Verify the code number in the Tabular Index**

Alphabetic Index

- **Locate main term in Alphabetic Index**
  - Condition listed as main term in Volume 2, usually expressed as a noun
  - General terms – admission, encounter, and examination used to locate supplementary V codes

Alphabetic Index cont'd

- Main term in Volume 3 may be specific title of procedure or general term (i. E. excision, incision, or removal)

- Some conditions and terms listed under more than one main term

Alphabetic Index cont'd

- If unable to locate main term check synonym, eponym, or other alternative term

- Perform a search of subterms, notes, or cross- references once main term is located (subterms provide more specific information)

Tabular Index

- Verify code number in the Tabular List
  - Once code has been located in the Alphabetic Index it should be verified in the tabular lists
  - Codes should no be assigned without this verification

Tabular Index cont'd

- Review the title for the chapter, section, and category for correct code
- Any significant discrepancy between the index and the tabular list should be reviewed in the Alphabetic Index for a more appropriate term
- read and follow all instructional notes when applicable;e

Tabular Index cont'd

- Pay particular attention to exclusion notes

- Main term is ordinarily listed with unspecified code; review other codes in the index for more specific codes

Basic Coding Guidelines

- **First coding principle:**
  - Use both the Alphabetic Index and Tabular List
  - Condition or procedure must first be located in the index

Basic Coding Guidelines cont'd

- Code is then verified in the Tabular List
- Follow all instructional notes to determine more specific subterms
- Consistent reference to the Alphabetic Index and Tabular Lists is imperative

Basic Coding Guidelines cont'd

- **Second basic principle:**

- **Assign codes to highest level of detail**

  - Assign three-digit disease code only when there are no four-digit codes within the category

  - Assign four-digit code only when there is no fifth-digit subclassification

Basic Coding Guidelines cont'd

- Assign a fifth-digit subclassification where provided
- Same principles apply for procedure codes
- No two-digit procedure codes are provided

Basic Coding Guidelines cont'd

- Three digits can only be used when no for-digit code is provided
- All digits must be used
- None can be omitted and none added
- Exception to rule : zero should be added as fourth-digit to rare codes requiring fifth-digit when no fourth digit is provided.

Residual Codes

- **Assign residual codes as appropriate: NEC and NOS**
  - Main term in alphabetic index usually followed by unspecified code
  - Code never assigned when more specific code available

Residual Codes cont'd

- Review index, titles, and inclusion notes in the

- subdivision under either three or four digit codes in Tabular Lists

Combination Codes

- Assign combination codes when available
  - Single code used to classify either two diagnoses, or
  - A diagnosis with an associated secondary condition or
  - A diagnosis with an associated complication

Combination Codes cont'd

- Combination codes located in the index by referring to subterm entries with particular reference to subterms following connecting words such as:

  - With
  - Due to
  - In
  - Associated with

Multiple Codes

- **Multiple Codes**
  - Use of more than one code to fully identify the component elements of a complex diagnostic or procedural statement
  - Complex statement involves connecting words or phrases such as:
    - With
    - Due to
    - Incidental to
    - Secondary to
    - Or similar terminology

Mandatory Multiple Codes

- Follow directions in Tabular List for use of additional code or codes that may provide more specificity

- Mandatory multiple coding

  - Term “dual” classification used to describe required assignment of two codes

  - Provides information about manifestation and associated underlying disease

Mandatory Multiple Coding cont'd

- Identified in the Alphabetic Index by the use of a second code in brackets (i.e. [ ]).
- First code identifies underlying condition
- Second code identifies the manifestation
- Both codes must be assigned and sequenced in order listed

Mandatory Multiple Coding cont'd

- In the Tabular List the need for dual coding is indicated by the presence of a "use additional code" note for the underlying condition, and a "code first underlying condition" note with manifestation code (printed versions list manifestation code in *italics)*

- Manifestations codes cannot be used as the principal diagnoses

Mandatory Multiple Coding cont'd

- Code for underlying condition must always be listed first except for an occasional situation where other directions provided

- Code in brackets in the Alphabetic Index can be used only as secondary code for specific condition or procedure indexed in this way

Discretionary Multiple Coding

- “code, if applicable, any causal condition first” – indicates multiple codes should be assigned only if causal condition documented as present

- “use additional code” – indicates multiple codes should be assigned only if condition mentioned is documented as present

Indiscriminate Multiple Coding

- Avoid indiscriminate multiple coding
  - Irrelevant information (i.e. signs and symptoms integral to the diagnosis)
  - Diagnostic tests (i.e. laboratory, x-ray, or electrocardiographic tests), unless diagnosis confirmed by physician
  - No code assigned for conditions which fail to meet UHDDS criteria for reporting
  - Unspecified codes when more specific code assigned

Unconfirmed Diagnoses

- **Code unconfirmed diagnoses as if established (inpatient setting)**
  - Diagnoses for inpatient at time of discharge qualified as “possible,” “probable,” “suspected,” “likely,” “questionable,” “?, or “rule out,” condition should be coded and reported as though diagnosis established
  - Exception applies to HIV infection/illness – code only cases confirmed by physician documentation)

Unconfirmed Diagnoses cont'd

- **Unconfirmed diagnoses guidelines do not apply to coding or reporting for outpatient encounters**
  - Principle diagnosis is the highest degree of certainty (i.e. symptoms, signs, or abnormalities)

Unconfirmed Diagnoses cont'd

- Caution should be used in coding unconfirmed diagnoses of conditions such as epilepsy, AIDS, and multiple sclerosis as if established

- Incorrect reporting can have serous personal consequences for the patient (i.e. inability to obtain driver's license and possible social security and job discrimination)

Rule Out vs. Ruled Out

- Important to distinguish between terms “rule out,” which indicates a diagnosis is still considered possible, and “ruled out,” which indicates a diagnosis originally considered likely is no longer a possibility
  - Diagnoses qualified by the term “rule out” are coded as if established for inpatient episodes of care in the same way as diagnoses describe as possible or probable

Rule Out vs. Ruled Out cont'd

- Diagnosis described as "ruled out" are never coded

- Alternative diagnosis should be coded, otherwise code for presenting symptom pr other precursor condition should be assigned

Acute and Chronic Conditions

- Conditions described as both acute (or subacute) and chronic should be coded according to the Alphabetic Index subentries for condition

  - If separate subterms for acute (or subacute) and chronic are listed at the same indentation level in the Alphabetic Index, both codes are assigned, with the acute code assigned first

  - In some cases, a combination code is provided for use for conditions described as both acute and chronic

Impending or Threatened Condition

- Code for condition described at time of discharge or conclusion of outpatient encounter as impending or threatened depends first on whether condition actually occurred

- If so, threatened/impending condition is coded as confirmed diagnosis

Impending or Threatened Condition cont'd

- If neither threatened/impending condition nor related condition occurred see Alphabetic Index

- Two questions:

  - Is condition indexed under main term threatened or impending?

  - Is there a subterm for impending or threatened under main term of condition?

Impending or Threatened Condition cont'd

- If such terms appear assign the code provided
- When neither term is indexed, the precursor condition which exists is coded
- No code is assigned for condition described as impending or threatened

Late Effects

- A late effect is a residual condition that remains after the termination of the acute phase of an illness or injury
  - Conditions may occur at any time after an acute injury or illness
  - No set period of time has to elapse before condition is considered a late effect

Late Effects cont'd

- Some late effects are apparent early
- Others may show up long after the original injury or illness has resolved
- Certain conditions due to trauma – malunion, nonunion, and scaring are inherent late effects no matter how early they appear

Late Effects cont'd

- Late effects include conditions reported as such or sequela of previous illness or injury

- A condition may be inferred as a late effect when the diagnostic statement includes the following terms:
  - Late
  - Old
  - Due to previous injury or illness
  - Following previous injury or illness
  - Traumatic, unless there is evidence of current injury

Locating Late Effects

- Codes for late effects are located by referring to the main term **Late** and the subterm effects in the Alphabetic Index of Diseases and Injuries (Volume 2)
  - Examples:
    - late effects of tuberculosis 137.0 – 137.4
    - Late effect of acute poliomyelitis 138
    - Late effect of cerebrovascular disease 438.0 – 438.9

Late Effects cont'd

- Two codes required:
  - Residual condition or nature of late effect
  - Cause of the late effect
  - Residual condition sequenced first, followed by code for cause of late effect, except in a few instances (where Alphabetic Index or Tabular List may direct otherwise)

Late Effects cont'd

- Three exceptions:
  - Residual effect is not stated, cause of late effect is used alone
  - No late effect code is provided in ICD-9-Cm, but condition is described as being late effect, only residual condition is coded
    - History or complications of previous surgery should be used for conditions described as due to previous surgery

Late Effects cont'd

- Late effect code has been expanded at fourth or fifth-digit level to include residual condition, only the cause of the late effect code is assigned
  - late effect category 438, cerebrovascular disease is the only category expanded this way to date

Late Effects cont'd

- **Late Effect vs. Current Illness or Injury**
  - Late effect codes are not used with codes for current injuries or illnesses of the same type, with one exception

Late Effects cont'd

- Code from category 438, late effects of cerebrovascular disease, is assigned as an additional code when a patient with residual effects from a earlier cerebrovascular disease is seen because of current cerebrovascular disease
- Example:
  - Patient with residual aphasia due to subdural hemorrhage two years ago who is admitted because of acute cerebral thrombosis
  - 434.0 cerebral thrombosis
  - 438.11 late effect of cerebrovascular disease, with speech and language deficits,aphasia